

Deputy Sheriff SmartCare Connect (Group Health) Benefits at a Glance



King County

Benefits, Payroll and
Retirement Operations

Plan Feature	Group Health Gold	Group Health Silver
<i>Provider choice</i>	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There's no coverage for out-of-network care unless indicated and approved/referred.	
<i>Annual deductible</i>	None	
<i>Copay, unless otherwise indicated</i>	You pay \$7	You pay \$20
<i>After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum</i>	Network: 100% Out-of-network: Limited emergency/out-of-area care	
<i>Annual out-of-pocket maximum</i>	Network: \$1,000/person or \$2,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.	Network: \$1,500/person or \$3,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.
<i>After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level</i>	Network only: 100%	
<i>Lifetime maximum</i>	No limit	

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver
<i>Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)</i>	Self-referrals to a network provider: \$7 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.	Self-referrals to a network provider: \$20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy, except for chiropractic services All other alternative care requires PCP referral.
<i>Ambulance services</i>	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)	

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver
<i>Applied behavioral analysis therapy for autism-spectrum disorders—outpatient</i>	100% after \$7 copay/visit No limit on number of days or visits. No age limit.	100% after \$20 copay/visit No limit on number of days or visits. No age limit.
<i>Chemical dependency treatment (requires preauthorization)</i>	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$7 copay/visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$20 copay/visit
<i>Chiropractic care and manipulative therapy (like all services, must be medically necessary)</i>	100% after \$7 copay/visit	100% after \$20 copay/visit
<i>Diabetes care training</i>	100% after \$7 copay/visit	100% after \$20 copay/visit
<i>Diabetes supplies (insulin, needles, syringes, lancets, etc.)</i>	Covered under prescription drugs	Covered under prescription drugs
<i>Durable medical equipment, prosthetics and orthopedic appliances</i>	80% when preauthorized	80% when preauthorized
<i>Emergency room care</i>	Network: 100% after \$75 copay/visit (\$75 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after \$125 copay/visit (\$125 copay is waived if admitted) Non-emergency care is not covered.	Network: 100% after \$100 copay/visit (\$100 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived if admitted) Non-emergency care is not covered.
<i>Family planning</i>	100% after \$7 copay/visit Infertility treatment is not covered.	100% after \$20 copay/visit Infertility treatment is not covered.
<i>Growth hormones</i>	100%, covered under prescription drugs	
<i>Hearing aids</i>	Not covered	
<i>Hearing exam (routine)</i>	100% after \$7 copay	100% after \$20 copay
<i>Home health care</i>	100%	
<i>Hospice care</i>	100% when preauthorized Certain limits apply; call plan for details.	
<i>Hospital care</i>	Inpatient: 100% Outpatient surgery: 100% after \$7 copay/surgery	Inpatient: 100% Outpatient surgery: 100% after \$20 copay/surgery
<i>Infertility services</i>	Not covered	
<i>Injury to teeth</i>	100% after \$7 copay	100% after \$20 copay
<i>Inpatient care alternatives</i>	100% when preauthorized	
<i>Lab, X-ray and other diagnostic testing</i>	100%	

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver
Maternity care	For delivery and related hospital care: 100% For prenatal and postpartum care: 100% after \$7 copay/visit	For delivery and related hospital care: 100% For prenatal and postpartum care: 100% after \$20 copay/visit
Mental health care	For inpatient care: 100% For outpatient care: 100% after \$7 copay/individual, family, couple or group session	For inpatient care: 100% For outpatient care: 100% after \$20 copay/individual, family, couple or group session
Neurodevelopmental therapy	For inpatient care: 100% For outpatient care: 100% after \$7 copay/visit	For inpatient care: 100% For outpatient care: 100% after \$20 copay/visit
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.	
Phenylketonuria (PKU) formula	100%	
Physician and other medical/surgical services	For inpatient care: 100% after \$7 copay For outpatient care: 100% after \$7 copay/office visit	For inpatient care: 100% after \$20 copay For outpatient care: 100% after \$20 copay/office visit
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after \$5 copay Preferred brand: 100% after \$5 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.	Generic: 100% after \$10 copay Preferred brand: 100% after \$15 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.
Prescription drug—Up to a 90-day supply through mail-order network only	Generic: 100% after \$10 copay Preferred brand: 100% after \$10 copay Non-preferred brand: Not covered	Generic: 100% after \$20 copay Preferred brand: 100% after \$30 copay Non-preferred brand: Not covered
Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after \$7 copay/visit	100% after \$20 copay/visit

Covered Expenses	SmartCare Connect Gold	SmartCare Connect Silver
Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema)—Call plan for more information.	100% depending on services provided; copays may apply	100% depending on services provided; copays may apply
Rehabilitative services—Inpatient and outpatient	<p><i>For inpatient care:</i> 100%, up to 60 days/calendar year</p> <p><i>For outpatient care:</i> 100% after \$7 copay/visit, up to 60 visits/calendar year</p>	<p><i>For inpatient care:</i> 100%, up to 60 days/calendar year</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit, up to 60 visits/calendar year</p>
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility	
Smoking cessation	<p>100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear[®] Quit for Life[™] Program, when prescribed by Group Health PCP</p> <p>No annual or lifetime limit</p>	
Sterilization (tubal ligation or vasectomy)	100% after \$7 copay	100% after \$20 copay
Temporomandibular joint (TMJ) disorders	<p><i>For inpatient care:</i> 100%</p> <p><i>For outpatient care:</i> 100% after \$7 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>	<p><i>For inpatient care:</i> 100%</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>
Transplants (certain services only)	<p>Inpatient: 100%</p> <p>Outpatient: 100% after \$7 copay</p> <p>Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.</p>	<p>Inpatient: 100%</p> <p>Outpatient: 100% after \$20 copay</p> <p>Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.</p>
Urgent care (ear infections, high fevers, minor burns)	100% after \$7 copay/visit	100% after \$20 copay/visit
Vision exams	100% after \$7 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)